

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO JUN 24 2019
BY ANDREA GERBER ANALYST

XAVIER BECERRA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General
JOSEPH F. MCKENNA III
Deputy Attorney General
State Bar No. 231195
600 West Broadway, Suite 1800
San Diego, California 92101
P.O. Box 85266
San Diego, California 92186-5266
Telephone: (619) 738-9417
Facsimile: (619) 645-2061

Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

Case No. 800-2016-028644

BRET ROBERT GERBER, M.D.
5150 Roxbury Road
San Diego, California 92116-2142

A C C U S A T I O N

Physician's and Surgeon's Certificate
No. G79213,

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs, and not otherwise.

2. On or about June 22, 1994, the Medical Board issued Physician's and Surgeon's Certificate No. G79213 to Bret Robert Gerber, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

JURISDICTION

3. This Accusation is brought before the Medical Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded which may include a requirement that the licensee complete relevant educational courses, or have such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states, in relevant part:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"..."

6. Unprofessional conduct under section 2234 of the Code is conduct which breaches the rules or ethical code of the medical profession, or conduct which is unbecoming to a member in good standing of the medical profession, and which demonstrates an unfitness to practice medicine. (*Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, 575.).

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Gross Negligence)**

3 8. Respondent has subjected his Physician's and Surgeon's Certificate No. G79213 to
4 disciplinary action under sections 2227 and 2234, as defined in section 2234, subdivision (b),
5 of the Code, in that Respondent committed gross negligence in his care and treatment of Patients
6 A and B,¹ as more particularly alleged hereinafter:

7 9. On or about July 13, 2016, Respondent brought two boxes of syringes with attached
8 needles into Scripps Coastal Medical Center's (SCMC) Hillcrest Pediatrics office where he
9 worked as a pediatrician. Prior to bringing them into the office, Respondent had stored the boxes
10 of syringes at his private residence. The syringes and needles themselves were originally
11 prescribed for an individual other than Respondent, and they had an expiration date of 2008.

12 10. The two boxes of syringes were not purchased by or on behalf of SCMC and,
13 therefore, were unauthorized and unsanctioned by SCMC for any use or purpose at the Hillcrest
14 Pediatrics office. One box contained 10 ml syringes, and the other box contained yellow-banded
15 syringes with 23 gauge needles attached to the syringe. SCMC did not stock or use 23-gauge
16 needles at the Hillcrest Pediatrics office location.

17 11. On or about July 13, 2016, Medical Assistant N.Z. was working at SCMC's Hillcrest
18 Pediatrics office and had worked there with Respondent for approximately ten years. She saw
19 Respondent bring two boxes into the office that same day. He told her that he had been storing
20 the enclosed syringes and needles at his home and that he intended to take the needles off and use
21 the syringes for patient care. After noticing that one of the boxes contained 23-gauge needles,
22 Medical Assistant N.Z. told Respondent that he could not use 23-gauge needles for patient care
23 because they were not safety needles.

24 12. On that same day, Medical Assistant N.Z. observed Respondent retrieve a needle
25 from one of the two boxes and take it into an examination room where he was seeing a patient.

26
27 ¹ To protect the privacy of all patients involved, patient names have not been included in
28 this pleading. Respondent is aware of the identity of the patients referred to herein.

1 She later reported her observations to a supervisor at SCMC, who told her to retrieve the sharps
2 container² from the examination room. Upon examination of the contents of the sharps container,
3 she identified a single yellow-banded syringe with an attached 23-gauge needle among the other
4 discarded syringes. Medical Assistant N.Z. located the two boxes of syringes and needles in the
5 office and examined their contents, which contained dead insects and what appeared as insect or
6 rodent droppings. The boxes also contained syringe packages that appeared chewed on.

7 **13. Patient A**

8 (a) On or about July 13, 2016, the same day that he brought the
9 unauthorized 23-gauge needles to SCMC's Hillcrest Pediatrics office, Respondent
10 saw Patient A, a then-2-year-old female, for an unknown viral infection. Patient A
11 had developed a rash with multiple lesions and it had spread to different areas of
12 her body. Respondent documented in Patient A's chart note for this visit that he
13 had "cultured" one of the lesions to identify the virus. Under the procedure section
14 of the chart note, Respondent wrote, "I wiped the toe vesicles with alcohol pad and
15 derroofed with a 23 g needle to reveal a small amount of clear fluid. This was sent
16 for viral culture." Respondent electronically signed the chart note for this visit on
17 July 13, 2016.

18 14. Respondent committed gross negligence in his care and treatment of Patient A
19 including, but not limited to, the following:

20 (a) Respondent used a 23-gauge needle that was unauthorized for use at SCMC's
21 Hillcrest Pediatrics office to perform a medical procedure on Patient A.

22 **15. Patient B**

23 (a) On or about July 13, 2016, the same day that he brought the unauthorized
24 23-gauge needles to SCMC's Hillcrest Pediatrics office, Respondent saw Patient B,
25 a then-10-year-old female, for an infection due to a bee sting. Patient B had

26
27 ² A sharps container is a hard plastic container that is used to safely dispose of
28 hypodermic needles and other sharp medical instruments. Needles are dropped into the container
through an opening in the top.

1 developed redness and swelling on her arm at the site of the bee sting. Respondent
2 documented in Patient B's chart note for this visit that the redness and swelling had
3 increased over the last twenty-four hours, and that he removed the remaining pieces
4 of stinger from Patient B's arm. Under the procedure section of the chart note,
5 Respondent wrote, "Stinger area prepped with H2O2 and 23 gauge sterile needle
6 used to lift off the eschar and remove two small pieces of particulate matter, most
7 likely stinger, from a small wound that is moist on the inside without frank d/c. No
8 bleeding. Area dressed with triple abx and bandage without complication."
9 Respondent electronically signed the chart note for this visit on July 13, 2016.

10 16. Respondent committed gross negligence in his care and treatment of Patient B
11 including, but not limited to, the following:

12 (a) Respondent used a 23-gauge needle that was unauthorized for use at SCMC's
13 Hillcrest Pediatrics office to perform a medical procedure on Patient B.

14 **SECOND CAUSE FOR DISCIPLINE**

15 **(Repeated Negligent Acts)**

16 17. Respondent has further subjected his Physician's and Surgeon's Certificate
17 No. G79213 to disciplinary action under sections 2227 and 2234, as defined in section 2234,
18 subdivision (c), of the Code, in that Respondent committed repeated negligent acts in his care
19 and treatment of Patients A, B, and C, as more particularly alleged hereinafter:

20 18. **Patient A**

21 (a) Paragraphs 8, 9, 10, 11, 12, 13, and 14, above, are hereby incorporated
22 by reference and realleged as if fully set forth herein.

23 19. **Patient B**

24 (a) Paragraphs 8, 9, 10, 11, 12, 15, and 16, above, are hereby incorporated
25 by reference and realleged as if fully set forth herein.

26 20. **Patient C**

27 (a) Respondent began seeing Patient C as his pediatrician since his birth in
28 December 2012. Patient C had had a complicated medical history involving

1 hypotonia, and he had been seen by multiple medical experts due to the condition
2 since he was six months old.

3 (b) On or about March 3, 2015, Respondent saw Patient C for a recurrent
4 cough and fever lasting for two days. A medical assistant took Patient C's vital
5 signs and documented the following values in the chart note for this visit: oxygen
6 saturation was 92%; respiratory rate was 38; and heart rate was 160.

7 (c) During the visit, Respondent examined Patient C and documented that
8 he did not appear to have pneumonia or an ear infection. Respondent further
9 documented that Patient C had been febrile, and that he appeared hoarse and
10 struggling with a painful cough. Respondent prescribed a steroid (prednisolone) to
11 be taken by Patient C for next three days.

12 (d) Respondent did not document anywhere in the March 3, 2015, chart
13 note that he had evaluated and assessed Patient C's abnormal vital signs including,
14 low oxygen saturation (92%); high respiratory rate (38); and high heart rate (160).
15 Furthermore, Respondent did not clearly document an evaluation and assessment
16 for croup as a possible diagnosis, even though he prescribed a steroid to this
17 patient as if he was treating him for croup.

18 21. Respondent committed repeated negligent acts in his care and treatment of Patient C
19 including, but not limited to, the following:

20 (a) Respondent failed to document any assessment of Patient C's low
21 oxygen saturation in the chart note for the March 3, 2015 visit;

22 (b) Respondent failed to document any assessment of Patient C's high
23 respiratory rate in the chart note for the March 3, 2015 visit;

24 (c) Respondent failed to document any assessment of Patient C's high heart
25 rate in the chart note for the March 3, 2015 visit; and

26 (d) Respondent failed to fully document an evaluation and assessment of
27 Patient C's presenting condition for the March 3, 2015 visit.

28 ////

1 **THIRD CAUSE FOR DISCIPLINE**

2 **(Failure to Maintain Adequate and Accurate Medical Records)**

3 22. Respondent has further subjected his Physician's and Surgeon's Certificate
4 No. G79213 to disciplinary action under sections 2227 and 2234, as defined in section 2266, of
5 the Code, in that Respondent failed to maintain adequate and accurate records in connection with
6 his care and treatment of Patient C, as more particularly alleged hereinafter:

7 23. **Patient C**

8 (a) Paragraphs 20 and 21, above, are hereby incorporated by reference
9 and realleged as if fully set forth herein.

10 **FOURTH CAUSE FOR DISCIPLINE**

11 **(Unprofessional Conduct)**

12 24. Respondent has further subjected his Physician's and Surgeon's Certificate No. G79213
13 to disciplinary action under sections 2227 and 2234 of the Code, in that Respondent has engaged
14 in conduct which breaches the rules or ethical code of the medical profession, or conduct which is
15 unbecoming to a member in good standing of the medical profession, and which demonstrates an
16 unfitness to practice medicine, as more particularly alleged in paragraphs 8 through 23, above,
17 which are hereby incorporated by reference and realleged as if fully set forth herein.

18 **DISCIPLINARY CONSIDERATIONS**

19 25. To determine the degree of discipline, if any, to be imposed on Respondent,
20 Complainant alleges that on or about July 28, 2015, in a prior disciplinary action entitled "In the
21 Matter of the Accusation Against: Bret Robert Gerber, M.D.," Case Number 10-2013-235201, the
22 Medical Board of California issued a decision revoking Respondent's Physician's and Surgeon's
23 Certificate No. G79213, staying that revocation, and placing Respondent on probation for two (2)
24 years on various terms and conditions. The Medical Board of California imposed discipline on
25 Respondent in this matter based on findings that he had violated a state statute regulating
26 dangerous drugs or controlled substances; he had admitted to a history of recreational drug use;
27 and he had committed general unprofessional conduct. That decision is now final and is
28 incorporated by reference as if fully set forth herein.

1 PRAYER

2 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
3 and that following the hearing, the Medical Board of California issue a decision:

4 1. Revoking or suspending Physician's and Surgeon's Certificate No. G79213, issued to
5 Respondent Bret Robert Gerber, M.D.;


6 2. Revoking, suspending or denying approval of Respondent Bret Robert Gerber,
7 M.D.'s, authority to supervise physician assistants pursuant to section 3527 of the Code, and
8 advanced practice nurses;

9 3. Ordering Respondent Bret Robert Gerber, M.D., to pay the Medical Board the costs
10 of probation monitoring, if placed on probation; and

11 4. Taking such other and further action as deemed necessary and proper.

12
13 DATED:

14 June 4, 2019

15 
16 KIMBERLY KIRCHMEYER
17 Executive Director
18 Medical Board of California
19 Department of Consumer Affairs
20 State of California
21 Complainant

22
23
24
25
26
27 SD2019700600
28 Doc.No.82178088